

## CME and the Medical Schools

MEDICAL SCHOOLS throughout the nation are beginning to assess, or reassess, their role and responsibility for the education of practitioners—or what is more commonly called continuing medical education (CME). This reevaluation is coming about partly as a result of a growing recognition that practitioner education is indeed part of a continuum of medical education which begins in medical school — or before — and continues through a lifetime of professional practice. But also it is occurring because of increasing professional and public concern with the continuing competence of practicing physicians in these times of rapid progress in medical science and rapid change in medical practice. Both the administration and the faculties of medical schools are becoming increasingly aware of the extent of the contribution of medical schools and their faculties to CME, whether under the auspices of the medical schools or not. And the fact that at least 16 states now require CME for physician relicensure has drawn the attention of the medical school faculties in those states to CME in a very personal way.

In California the Medical Injury Compensation Reform Act of 1975 (AB 1xx) requires that physicians have continuing medical education as a requirement for relicensure. In the wording of this law, continuing medical education is linked to continuing professional competence, to the physician's individual practice profile and to quality review, which in turn is again linked to CME. If one thinks about what these words mean and what these linkages entail, one senses that the enactment of this law may mark the beginning of a new era for CME. It asks CME to do some things it does not yet know how to do, but must learn to do, if it is to fulfill the public expectation of quality assurance in a physician's practice.

There are many actors on the CME stage. In the center as the main focus are the practicing physicians. But also on stage are professional associations, specialty societies, the public in the form of licensing boards, and medical school faculty members. The medical schools themselves may be thought of at present as being somewhere in the wings, perhaps getting ready to come on stage. It is noteworthy that each of the actors plays a lead role during some part of the CME scenario.

It seems likely that medical schools will soon come onto this stage and that they too will have a lead part to play. It seems certain that the role will require greater collaboration with the other actors than has been the case to date. Medical schools seem particularly qualified to help determine what new knowledge should be incorporated into practice, what is obsolete and should be discarded, and what remains current and should be affirmed. Medical schools can contribute a great deal to a better understanding and definition of physician competence, to the development of better educational methods and to research in quality assurance. But each of these will require substantial collaboration and interplay with the other actors on the CME stage.

In a sense, in developing their role in CME the medical schools may become like Janus, looking two ways at once—on the one hand studying and teaching in the world of science, and on the other studying and teaching in the world of practice. A great spin-off would be that practitioner education would affect undergraduate education as well as vice versa, with CME the conduit in both directions.

—MSMW

## Management of Diabetic Ketoacidosis in Children

DEATH IN CHILDREN AND ADOLESCENTS with diabetic ketoacidosis is uncommon, provided early and appropriate treatment is given. Mortality in children has been attributed to cerebral edema<sup>1,2</sup> and inadequate replacement of potassium deficits.<sup>3</sup> One approach to reduce mortality is a modification of insulin dosage. Claims have also been made that morbidity of such patients is also lessened.

As reported in this issue by Kaufman and co-workers, the use of small doses of insulin, which are administered by continuous intravenous infusion, has achieved impressive results in the treatment of diabetic ketoacidosis in children<sup>4-7</sup>

Kaufman and co-workers, and other proponents of low-dose insulin, claim that its major benefits